The Policy Environment Score

Measuring the Degree to Which the Policy Environment in Nigeria Supports Effective Policies and Programs for Family Planning, Adolescent Reproductive Health and HIV/AIDS/STI

2002

The Federal Ministry of Health

(Department of Community Development and Population Activities)

&

The POLICY Project

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Foreword

Nigeria is committed to improving the reproductive health and well being of its citizens. This is shown through various initiatives to improve access to affordable reproductive health services. This commitment is further expressed through its adoption of the National Reproductive Health Policy of 2001, which reflects the international Conference on Population and Development (ICPD) Declaration of 1994 and the United Nations General Assembly Declaration of Commitment on HIV/AIDS of 2001.

Reproductive health services and programmes to ensure continued access to quality health care are implemented in a policy environment that is not under the direct control of programme implementers, but which largely affects the outcome of such interventions. It is therefore only appropriate that the environment in which the activities are carried out be assessed periodically to determine the opportunities and challenges within the environment. This will enable us take advantage of the opportunities and develop strategies for overcoming the challenges inherent in the policy environment.

This Policy Environment Score (PES) is a study that gauges the present policy environment in which reproductive health programmes are being implemented. It gives an idea of the relative strengths of various components of the policy environment, highlighting the improvements made over time, and the components in need of attention.

The results of this study will be another source of information that will be used for planning future programmes and reprogramming present initiatives. It is expected that this will lead to more effective programmes that will improve the present health indices and the general standard of living of Nigerians.

Dr. M.S. Amaeshi
Director, Dept. of Community Development and Population Activities
December 2003

Acknowledgement

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Our appreciation goes to the POLICY Project and USAID, Nigeria for their support and technical assistance for the development of this report.

Our appreciation also goes particularly to all stakeholders and respondents to the PES Questionnaires across the country. Specifically the efforts and commitments of Dr. O. Fajemisin, Dr T. Avbayeru, and Mrs C. Ibeawuchi to the development of the report are highly commended.

I do sincerely look forward to the use of the report for policy dialogue and programme decisions that will support improvements in reproductive health and HIV/AIDS service delivery in Nigeria.

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December 2003

Policy Environment Score

Introduction

After many years of program implementation in countries, one of the lessons learnt by program planners and implementers is that a great deal of the success of programs depends on a supportive and enabling policy environment. While the importance of a supportive policy environment has been recognized, less effort has been devoted to determining what constitutes that environment and how to measure changes or improvements in it over time.

The Policy Environment Score (PES) has been designed to measure the overall status of the policy environment in a particular country, evaluating changes in the policy environment over time, and identifying those areas most in need of improvement with particular focus on access to high quality reproductive health services including family planning, adolescent reproductive health and HIV/AIDS, safe motherhood and post-abortion care.

The PES is designed to provide a quick assessment of the policy environment at low cost. It necessarily contains a number of items that depend on the judgment of experts. It is not designed to provide a comprehensive assessment of the policy environment, but to be part of a system for measuring the impact of policy activities.

The policy environment score was first undertaken in Nigeria in 2000 by the POLICY Project. Though the report was not officially published the results were used to inform the review of the National Population Policy. This 2002 assessment of the policy environment in Nigeria in the year 2002 is being carried out by the Department of Community Development and Population Activities with the technical assistance of the POLICY Project, Nigeria. The knowledge gained will be used in informing future planning for reproductive health activities in the areas of family planning (FP), STI/HIV/AIDS and Adolescent Reproductive Health (ARH). It will also reveal areas of the policy environment that will also need improvement through advocacy and planning.

Conceptual Framework

Definitions

For the purpose of this evaluation **policy** is defined to be "actions, customs, laws or regulations by governments or other social/civic groups that directly or indirectly, explicitly or implicitly affect fertility, family planning or reproductive health activities". This definition to recognizes that policies can be direct or indirect and explicit or implicit. Through this definition the policy environment includes all factors that affect the performance of programs that are beyond the complete control of programs and program managers including national program managers. For the purpose of this particular evaluation population activities that affect mainly mortality, migration and spatial distribution are not included, but only health policies affecting aspects of reproductive health.

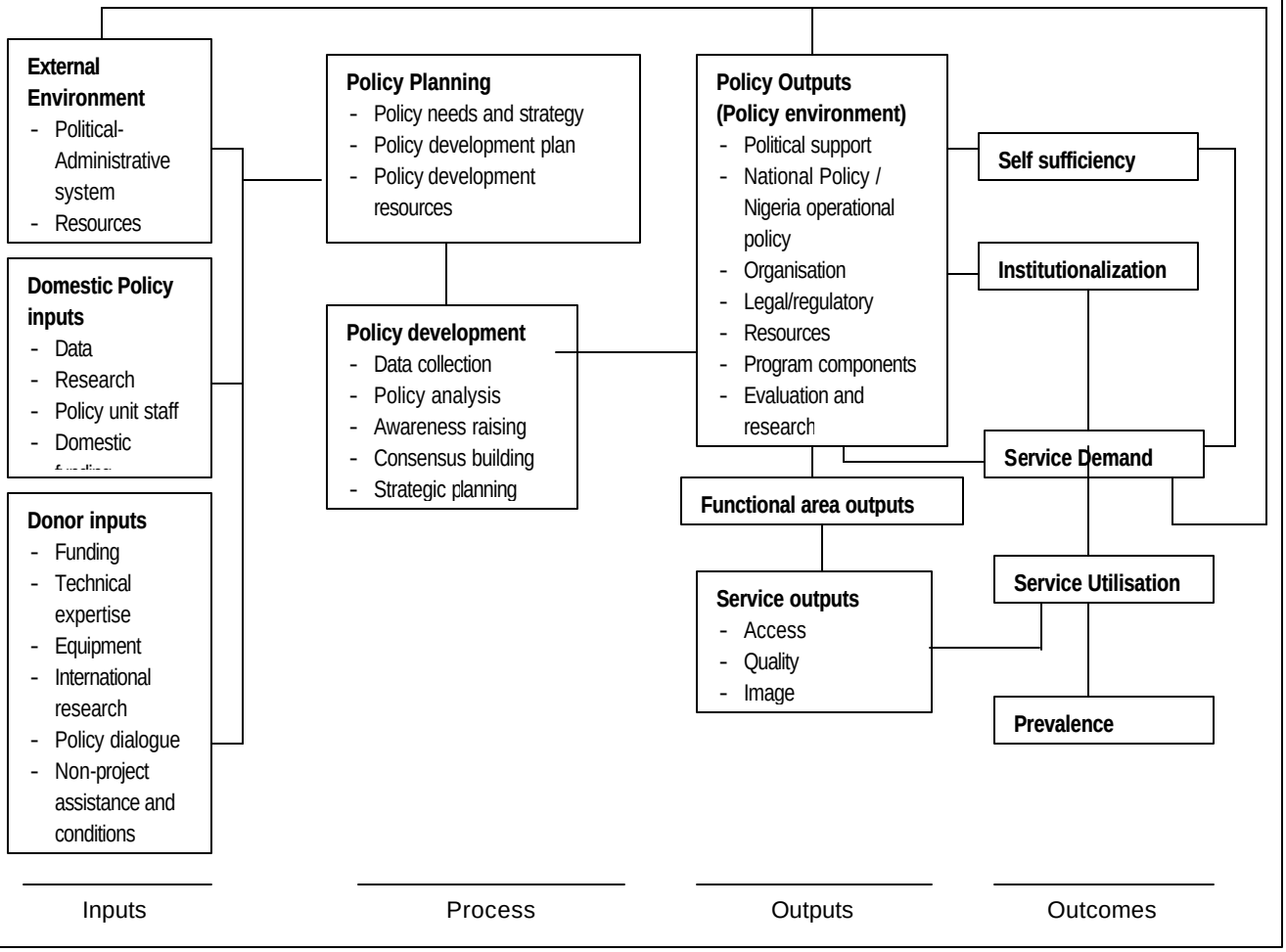
Factors which constitute a supportive policy environment include:

- political support and commitment at all levels, including supportive national policies, laws and plans;
- policies that meet client's expressed needs;
- operational policies that promote access, demand and quality, all the way down to the service level;
- adequate financial and human resources;
- active private sector participation; and
- Programs that are implemented according to policies.

Conceptual Framework for the Evaluation of Policy Activities

There is a large amount of literature written about the components of the policy environment and how the various elements interact to affect services and outcomes. The EVALUATION Project's working group (a USAID project) on the evaluation of population policy activities addressed this issue. Figure 1 shows the conceptual framework developed by the working group for the evaluation of the policy area. While this framework was developed primarily in reference to family planning programs, it is also appropriate for reproductive health programs more broadly.

Figure 1: Conceptual Framework for the Evaluation of the Policy Environment



The categories in the conceptual framework listed under "External Environment" and "Donor Inputs" are factors that are usually outside the influence of the domestic policy inputs (persons involved in improving the policy environment though they also affect the outcome of policy efforts and their outcome. While they are taken into consideration they are not assessed in the PES since they cannot be improved upon by policy activities.

The categories included in the conceptual framework under 'Domestic Policy Inputs,' 'Policy Planning,' and 'Policy Development' refer to inputs and processes used by policy activities to affect the environment. The "Policy Outputs" are the elements of the policy environment that policy activities attempt to influence for the better. The PES therefore assesses the output of policy inputs and processes. The outputs mentioned serve as the starting point for defining the categories of the policy environment score.

To the original items listed in the EVALUATION project, two categories have been added to the list: "Program Components" and "Evaluation and Research." The "Program Components" category is intended to explicitly capture whether or not specific components are included in the program by formal policy. The "Evaluation and Research" category is intended to capture whether these activities are present to support the process of policy formulation. Thus, the categories comprising the policy environment score are shown below:

1. Political Support
2. National Policy (or Policy Formulation)
3. Organizational Structure
4. Legal and Regulatory Environment
5. Program Resources
6. Program Component
7. Evaluation and Research

Methodology

BACKGROUND

Nigeria, with an estimated population of 126 million people[1], has a high growth rate of 2.9%[2]. The total fertility rate in the 1999 Nigeria Demographic and Health Survey (NDHS) was 5.2[3]; the contraceptive prevalence rate was 15% for all methods and 8.6% for scientific methods[3]. The maternal mortality rate is 800 per 100,000 live births[3]. The large population is young with a median age of 17 years[4].

The HIV/AIDS epidemic in Nigeria is growing. In 2001 the adult HIV prevalence was 5.8%; this was a continued upward trend from the previous prevalence. The ages that were found to be most affected were the 20 – 29 year age group. However there was a noticeable high prevalence among youths 15 – 19 years who were sexually active. The age of first sexual activity in 1999 NDHS was estimated to be 17 years for both sexes with females beginning sex earlier than males.

[1] National Population Commission. 1991 population census of the Federal Republic of Nigeria. Analytic report at the National level
[2] World Health report 2001 Annex table 1 Basic indicators for all countries
[3] National Population Commission 1999 Nigeria Demographic and Health survey
[4] National Population Commission. 1991 population census of the Federal Republic of Nigeria. Analytic report at the National level

The country has adopted a 3-tier health system that corresponds to the three-tier political structure of the country. The local governments are in charge of the primary health care facilities; the secondary health care facilities are provided and maintained by the state governments; and the tertiary health centres are controlled by the Federal Government. Health is on the concurrent list which implies that the federal government has little authority over what policies should be adopted at the state and local government levels but since most of the funding comes from the federal government, and largely because the federal government has shown leadership in policy decisions, building up capacity and providing technical assistance on health issues, most initiatives of the Federal Government are well received and adopted.

Reproductive health in Nigeria is supervised by the Federal Ministry of Health, Department of Community Development and Population Activities (CDPA). The priority areas as determined by the National Reproductive Health Strategic Framework and Plan (2002 – 2006) are:

1. Safe motherhood
2. Family planning
3. STIs and HIV/AIDS
4. Adolescent reproductive health
5. Harmful practices; reproductive rights and gender issues
6. Cancers of the reproductive system
7. Infertility and sexual dysfunction
8. Other RH issues, such as menopause and andropause

As in many countries, policies and programs pertaining to reproductive health are organized around the components of reproductive health The Policy Environment Score is intended to measure the policy environment for reproductive health program components and the PES questionnaires were developed to focus on various components of Reproductive Health. Of the above stated components of the reproductive health that are accorded priority in Nigeria, this assessment is limited to the Family planning (FP), STIs and HIV/AIDS and Adolescent Reproductive health (ARH). In future it might be possible to further incorporate other components of reproductive health.

Conduct of Study

Policy Project has developed prototype questionnaires, which were adapted to reflect the Nigerian situation. Three questionnaires collecting information on 3 components of reproductive health were used. The questionnaires are divided into units. The units collect information on political support, policy formulation, organisation and structure, program resources; evaluation and research and the respondent's professional status.

There were many similar questions for the components of Reproductive health investigated but there were also some different questions to reflect the various characteristics of each RH component (See Appendix 1 - 3).

The questionnaires were mailed to respondents with information on reason for the PES and instructions on how to fill them. Respondents were chosen on the basis of having sufficient experience and knowledge of the reproductive health situation in the country. They also represented different viewpoints. Persons who believed that they had limited knowledge in some components were asked to leave the questions for those sections unanswered. The respondents included:

- Government Program managers in ministries and national agencies involved in the management of Reproductive health activities
- Population and health specialists from donor and international organizations
- Program managers of international NGOs in Reproductive Health & HIV/AIDS
- Representatives of local NGOs
- University-based researchers, academicians and clinicians
- Representatives from women's groups (mainly professional bodies)

The entire process from the mailing of questionnaires to the return of responses lasted 5 months (October 2002 - March 2003).

Analysis

Analysis was performed using the Microsoft Excel software on a personal computer.

All items on the PES questionnaire were scored 0 – 4 by the respondents with 0 representing weak, and 4 representing strong. The first step in calculating the total score was to sum the individual item scores within a unit. These subtotals were converted to averages by dividing by the number of items that were scored. (This procedure computes an average score per item scored; thus, items that were not

scored by the respondent do not reduce the score.) These averages were converted into percentages by dividing by the maximum possible score for each unit. This approach standardizes the units in order that the number of individual items within a unit does not affect its contribution to the total score. The sum of all the weighted category scores is the total PES. The final score is adjusted to range from 0–100, with 100 indicating a perfect policy environment. The scores were compared with the scores generated in the first PES undertaken in 2000.

When analysing the items (questions) individually, the average score from 0 – 4 was taken. The score for these items was considered low when the mean score was less than 1.5, and was considered high when the score was more than 3.

Limitations

One major limitation was the poor and slow response from persons to whom the questionnaire was sent to. Out of about 80 questionnaires that were sent by post only 51 were returned filled. 15 were returned as unclaimed registered mail and 16 were unaccounted for in spite of the reminders. It was also important to limit the time of responding to a narrow range of time to ensure that respondents were evaluating and referring to the same period of time.

Traditionally only 30 responses are necessary to ensure wide enough viewpoints will be obtained. These viewpoints are expected to cut across the spectrum of stakeholders who should have enough knowledge of the policy environment and represent different viewpoints. When the present policy environment score was analysed it was discovered that there considerable representation from persons working in all sectors. There was no significant difference between those who did not respond the questionnaire and those who did. It is therefore expected that the PES score represents the view point of a wide range of stakeholders and characterises the true picture.

RESULTS

51 respondents participated in the survey. The various types of stakeholders in the area of reproductive health which included university based clinicians/academicians/researchers, local NGO officials, international IGO representatives, staff of international donor agencies, staff of multi-lateral bodies,

governmental civil servants working in the area of reproductive health and heads of professional bodies that have bearing on reproductive health. The break down is as seen in table 1 below.

Table 1: Type of stake holders questioned.

Parent organisation of respondents	No.
Federal Civil servants and Parastatal staff	10
International donors representatives	3
International NGO representatives	5
University based/researchers	12
Local NGO representatives	14
(UN organisations) representatives	2
Women's groups' representatives	4
Total no. of respondents	51

The study respondents were asked to answer only questions for which they believed they had enough knowledge. As a result of this not all respondents filled all components sections of the questionnaire and most respondents answering when filling the answered questionnaires left some of the questions unanswered. Similarly not all answered all questions within the sections they responded to. The number of respondents to the various sections is listed below in table 2.

Table 2: number of respondents that filled in the various sections of the PES Questionnaire

Section of Questionnaire	No. that answered the section
Family planning	48
Adolescent Reproductive Health	49
STI/HIV/AIDS	48
Total no of respondents	51

The Final PES Scores

The final PES scores were derived as stated above for each of the component investigated. The 2002 scores for the programs varied from a poor score of 43.2% for adolescent reproductive health to middle range score of 60.7% for STI & HIV/AIDS. The family planning program was in between with a score of 50.4%. In all programs, the PES shows that the country policy environment improved when compared to the year 2000. This increased was more marked in the STI/HIV/AIDS' and the

adolescent reproductive health component where the increase was 8.8% and 7.3% increase respectively. It was lowest in the family planning program where the increase was less than 5%.

Table 3 Final Policy Environment Scores for 2002 and 2000

	Year 2002 (%)	Year 2000(%)	Change (%)
Family Planning	52.4	48.0	4.4
Adolescent RH	43.3	35.9	7.4
STD-AIDS	60.8	52.0	8.8

Comparison of Policy Environment Scores by Elements of Program

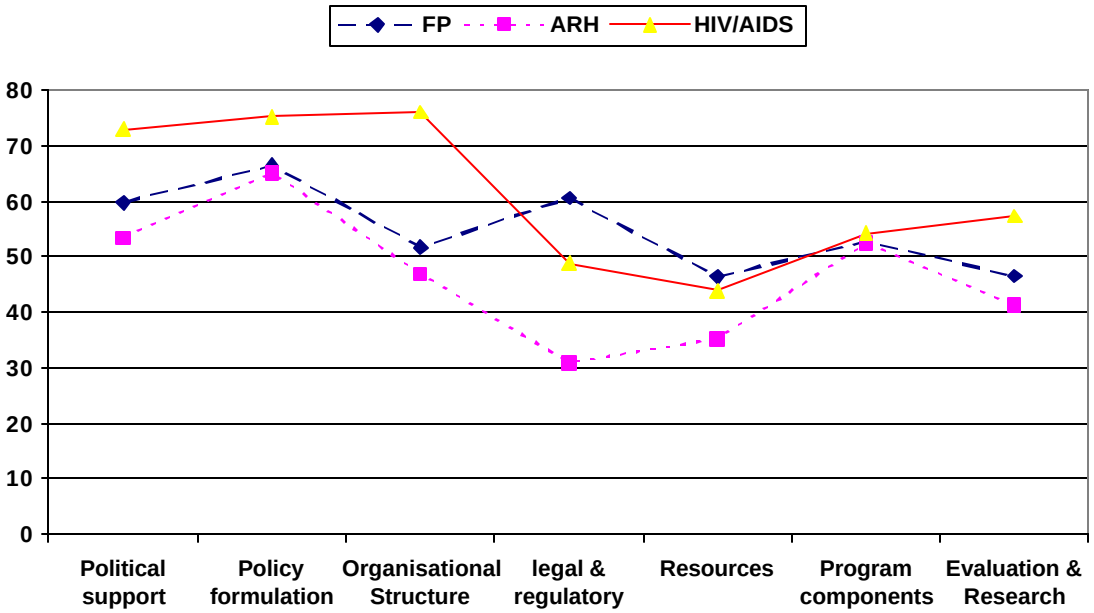
A study was made of the scores awarded by the respondents to the various components that make up the policy environment in an attempt to determine the areas of weakness. Table 4 shows the results of this exercise.

Table 4. Comparison of Policy Environment Scores by component of Policy Environment

	Family Planning (%)		Adolescent Reproductive health (%)		STI & HIV/AIDS (%)	
	2002	**2000**	**2002**	**2000**	**2002**	**2000**
Political support	59.8	51.7	53.4	46.0	73.0	68.3
Policy formulation	66.4	62.8	65.1	57.0	75.3	72.2
Organisational Structure	51.7	40.4	46.9	37.7	76.1	71.0
Legal/regulations	60.6	59.7	30.9	19.3	48.8	36.0
Resources	46.4	33.6	35.2	27.6	43.9	38.6
Programs components	52.8	49.3	52.4	40.7	54.2	40.8*
Evaluation and Research	46.5	42.7	41.2	28.3	57.3	53.2

* The 2000 figures program components did not include the care components which were evaluated separately with a score of 33.5%

Figure 4. A Comparison of PES for the RH Components in Nigeria (2002)



The table shows that the differences in the policy environment for the three components of reproductive health studied were considerable. The policy environment for the family planning programs was shown to be strong in policy formulation and the legal regulations while the weaknesses were in the evaluation and research and the availability of resources for programming. In the adolescent health component the only strong point of the policy environment was the policy formulation while the weak points included the legal/regulatory environment, program resources, the organisational structure, and the evaluation and research. Lastly in the STI/HIV/AIDS component the strong points were policy formulation and political support but to this were included organisational structure. The weak points included program resources and the legal/regulatory environment.

In summary the policy environment for all three programs is strong on policy formulation but weak in the availability of resources to implement the necessary activities. Interestingly in all of the elements for all three RH components the score for 2002 was better than in 2000.

Family Planning Program Environment

The family planning program was assessed to have an average policy environment which would suggest that the environment though not in opposition to family planning programs does not facilitate the planning and implementation of family planning programs, or improve their outcome. The respondents agreed that there was appreciable political support and policies had been formulated for the program,

> *"Since we returned from Cairo, it could be said that much has been done to put some of these issues on the agenda of the government, the RH department of the FMOH can be assessed to have succeeded in pushing some of the technical issues of RH unto the stage of policy …however much needs to be done in terms of translating the policy into action by way of making funds available to:*
>
> *i. To build up capacity of providers*
> *ii. Make institutions strong and equipped for FP/RH activities*
> *iii. Enlisting the support of the private sector for funds*
> *iv. Making the education task fund provide resources for sexuality education for the youth"*

In spite of the successes, respondents felt that a major weakness in the policy environment was the opposition to some family planning initiatives by religious leaders to family planning. An academician working in northern Nigeria stated:

"A lot of Islamic followers and learned leaders do not favour family planning…they believe it is 'western propaganda'

Respondents were also of the opinion that there not enough evaluation or research was being done, and when present, the results were not visibly for policy analysis of programming.

> *"Though some of these statistics/ data exist through the assistance of donor agencies (in many cases) the question arises as to what extent policy makers are willing to use them honestly and effectively"*

The organisational structure was rated fair but there was common understanding that the coordination of activities by the coordinating body was weak, especially the coordination between activities of the National government, and the State and local governments. Also the coordination of NGOs, private sector and International donors

> *"Private sector activities are hardly ever monitored, recorded or recognised … a proper coordinating structure is required"*

Specific questions were analysed. It was seen that even within element areas there were some factors which the respondents considered to be strengths in the policy environment while others were considered major weaknesses. The items that were rated as high or low in the policy environment are listed in the table 5 below. As aforementioned items were rated high if the mean score for the item was greater than 3 and as low if the mean score was less than 1.5.

Highly rated aspects were the fact that written documents existed which stated the government's opinion on family planning and also its plans which were positive. Also appreciated was the fact that family planning campaigns were permitted. The aspects rated poorly included amongst others: the coordination between the government, local governments and NGOs in the execution of family planning programs and the delivery of services; the enforcement of legal age at marriage; and the government funding for FP activities.

Table 5: High and Low Rated Items for Family Planning Programs

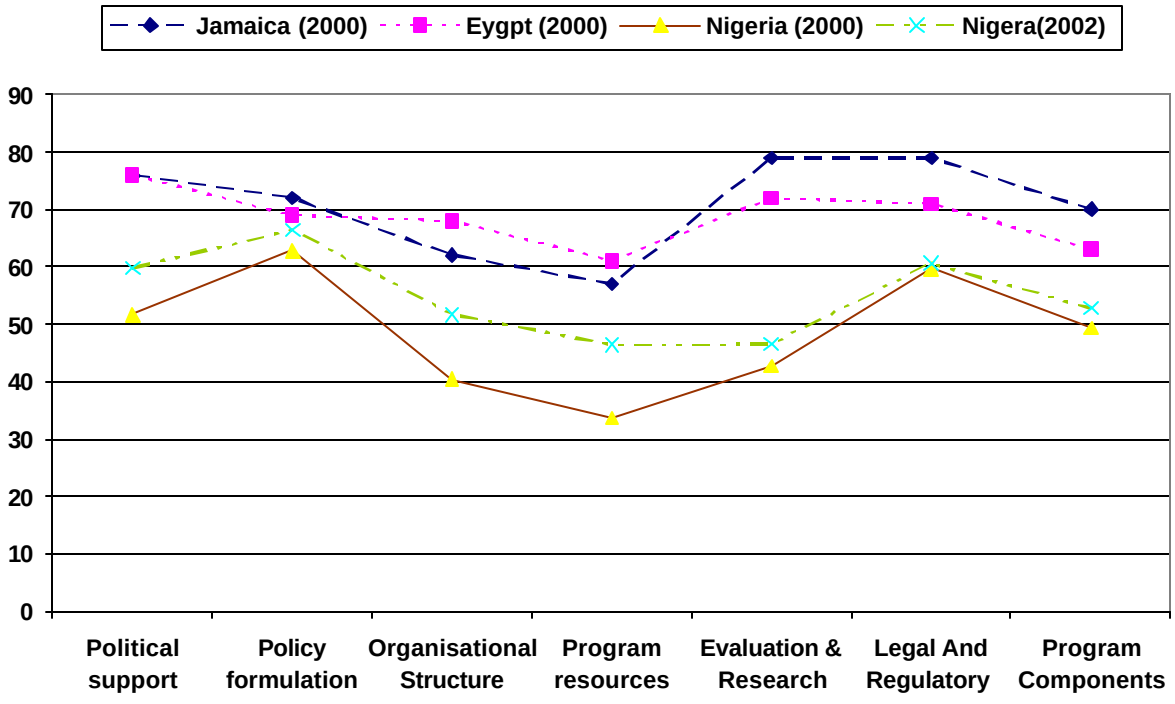
High Rated items	▪
Political Support	▪ Family planning media campaigns are permitted
	▪ NGO leaders support effective FP policies and programs
Policy Formulation	▪ A national policy exists that is favourable to FP
	▪ A formal FP program exists within the National policies
Legal and regulatory	▪ No medical barriers for use of condoms and spermicidals
	▪ No eligibility barriers for condoms
Low Rated items	▪
Political Support	▪ The Support of Political parties for FP policies and programs
	▪ The support of major religious organisations for FP policies and programs
Organisational structure	▪ The collaboration of other Ministries with the FMOH to help with FP Program implementation
	▪ The coordination between activities of the National government , State and local governments, NGOs, private sector and International donors
Legal and regulatory	▪ The enforcement of the legal age at marriage for females and males
Program resources	▪ Amount of funding from Government
	▪ Accessibility of FP services to rural clients

	▪ Allocation of resources by health priority guidelines
Evaluation and research	▪ Special studies undertaken to address leading policy issues

Though it is understood that comparing countries' policy environment through their PES is difficult due to the fact that the score is a computation of varied subjective scores, comparison may show how country citizens perceive their policy environment. The Nigerian PES is here compared with the PES score for Jamaica a Caribbean country and Egypt, an African country. The result of this comparison is seen in figure 4.

From the figure it is apparent that in both years, Nigeria falls below Jamaica and Egypt in most components except for policy formulation where it lags on slightly. The figure also shows that in most components of the Nigerian policy environment, there was an improvement of the score except for program resources.

Figure 4. A Comparison of FP PES of some Countries



Adolescent Reproductive Health Program

The adolescent Reproductive Health program was assessed to have a poor policy environment which will suggest that the environment is rather antagonistic to adolescent reproductive health programs. This is shown by its low policy environment score of 43.2%. Though on the whole the score was low, it was an improvement on the score for 2000.

Political support was poor as a result of low support by religious leaders and political parties

"Cultural taboos still diminish or enshroud explicit ARH services"

"There is a general outcry against introduction of sexuality education generally and in schools specifically, by all religious leaders… and politicians alike. The issue needs to be treated carefully for success"

In the policy environment for ARH, only policy formulation was considered good. Most respondents had negative opinions about the implementation of any written policies.

"Most of the work in this area is by NGOs and foreign agencies. Also private organisations have shown some concern but nationally, the government has not displayed a strong will to address this problem"

"To my knowledge, programmes to support ARH are not yet on ground or are ineffective. Yet this is what we need now in a youthful population like Nigeria's and an era of AIDS"

"Our ARH services are largely still very weak, disjointed and poorly funded and implemented"

There was a ray of hope as illustrated in a single state of the country.

"ARH programmes are only being implemented by NGOs except in Oyo state. There, 40 youth friendly clinics have been established within the primary health care centres. This was a collaborative program between the Oyo State Ministries of Health and Education, and ARFH with DFID support"

"Expanded life Planning Education (ELPE) programme takes into cognisance major reproductive health problems of adolescents in Oyo state. There are not less than 40 youth friendly clinics for adolescent reproductive health issues locate in LGAs in the state. The clinics are monitored by youth friendly personnel"

Other areas of concern in the policy environment for ARH included the poor coordination between various the levels and the public and private sector

"Coordination between the various levels is inappropriate"

"Private sector is not adequately defined. Nobody seems to monitor activities within this sector"

Weaknesses included the regulations and legal restrictions that surround providing adolescent reproductive health services, the paucity resources for ARH activities and the lack of use of operational research and evaluation for policy formulation and to guide programming. The organisational structure was also considered weak.

The table 6 below shows that there were very few strengths. Strengths had mainly to do with the fact that NGOs were very much in support of ARH programs and the lack of legal or regulatory barriers on the use of condoms and spermicidals. The weaknesses include the low support of major religions and political parties for ARH; a lack of policy support to allow female youth with pregnancies continue their education; the lack of ARH services in the public health services; the weak coordination of services and programs offered by government, NGOS and the private sector; the lack of FP services at points friendly to adolescents; and a weak evaluation and research component that feeds into informing policy and planning. The evaluation and research was weak in all items. This was put succinctly by a respondent: *"Information on ARH is extremely limited."*

Table 6: High and Low Rated Items for Adolescent Reproductive Health Programs

High Rated items	▪
Political Support	▪ NGO leaders support effective ARH policies and programs
Legal and regulatory	▪ No medical barriers for use of condoms and spermicidals
	▪ No eligibility barriers for condoms
Low Rated items	▪
Political Support	▪ support of Political parties for effective ARH policies and programs
	▪ Support of major religious organisations for effective ARH policies and programs
Policy Formulation	▪ The existence of a national coordinating body to address ARH issues which functions effectively
Organisational structure	▪ The availability of ARH services at Government Health facilities
	▪ There coordination between activities of the national government, local government, NGOs, private sector and international donors
	▪ The formal inclusion of private sector in ARH programs
Legal and regulatory	▪ The extent of favourable legal and regulatory climate to ensure that that unmarried adolescents are allowed to receive contraceptive services
	▪ Pregnant adolescent are allowed to continue with their education
Program resources	▪ The adequacy of Government funding for ARH programs
	▪ Resources for ARH are allocated by explicit health priority guidelines

Program components	▪ FP services for single adolescents are offered not only in the usual service delivery points but also in locations such as schools, youth centres etc.
	▪ Emergency contraception is an integral part of the ARH program
Evaluation and research	▪ Special studies are undertaken to address leading policy issues
	▪ The existence of a system to monitor and use secondary sources of information (census, surveys and local studies) for policy formulation and program planning.
	▪ The existence and effectiveness of service statistics system to inform ARH service policies and strategies
	▪ The existence or effectiveness of a system to provide policy makers and program managers with results of research and evaluation of ARH

STI & HIV/AIDS Programs

The STI and HIV/AIDS program was found to have a better policy environment than that of ARH or family planning. The policy environment score was 60.7% which will suggest that the environment is somewhat friendly to STI and HIV/AIDS programs. There is also a considerable improvement of the policy environment in 2002 when compared to 2000, as shown by the 8.7% increment in the PES score when the scores for both years are compared (Table 2)

Though the Policy Environment Score is considerably better than the other programs studied there are some elements of the policy environment which are noticed to be low, while other elements were fair or strong. Table 4 shows that while policy formulation and political support were quite high while there a noticeable weakness in the availability of program resources. This was highlighted by a government official. *"The present govt has demonstrated a willingness to combat the spread f HIV/AIDS. All that is needed is the prompt release of funds to implement the strategic plan"*

Most respondents considered the legal and regulatory environment an impediment to the control of the epidemic. While the organisational structure was good, a few persons were concerned about the level of coordination of activities in the national response to HIV/AIDS.

Coordination of activities in the HIV/AIDS program was considered a major challenge by most respondents.

"Coordination between national government, local governments, NGOs, private sector and international donors is almost non-existent. There is a need to put a proper structure in place…"

"The three tiers of govt need to coordinate their support for the prevention of STD and HIV/AIDS."

When items within the elements were studied some strengths and weaknesses of the policy environment of the STI/AIDS program were further brought to fore. These are shown in table 7.

The main strengths of the program include the high level of support of the program from the Federal Government; the existence of a HIV policy within and the fact that the AIDS control program is placed high in the government structure.

The weaknesses within the policy environment include inadequate funding for the care and support of persons living with or affected by HIV/AIDS; a weak coordination of government, local governments, NGOs, the private sector, and international donors; and the paucity of laws and regulations that deter discrimination against persons living with HIV/AIDS.

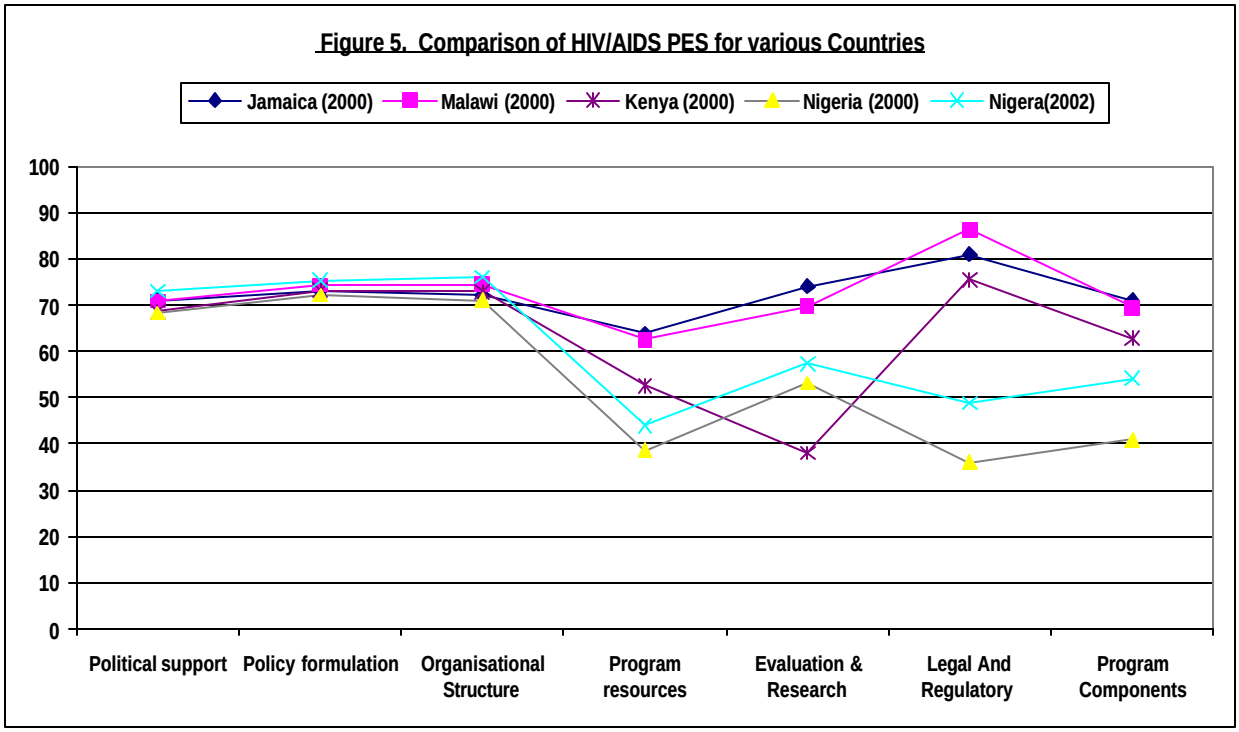
Table 7: High and Low Rated Items for STI & HIV/AIDS Programs

High Rated items	
Political Support	▪ Media campaigns are permitted
	▪ High level national Government support exists for effective STD and HIV/AIDS policies and programs
	▪ Professional associations support effective policies and programs.
	▪ NGO leaders support effective policies and programs
	▪ Public opinion supports effective policies and plans
Policy Formulation	▪ A national policy exists that is favourable to STI and HIV/AIDS prevention and management
	▪ A formal STD/HIV/AIDS program exists within the policy
Organisational structure	▪ The AIDS control program is placed high in the government structure
	▪ The director of the AIDS control program is full time and reports to an influential superior officer
Low Rated items	
Legal and regulatory	▪ The existence of anti-discrimination laws and regulation
Program resources	▪ The adequacy of funding for care of people living with HIV/AIDS
	▪ The adequacy funding to mitigate the effect of AIDS
Program components	▪ The existence of a functioning logistics system for drugs to

treat STDs and opportunistic infections.

- The availability of palliative drugs through the national health system.

Comparing the policy environment for HIV/AIDS in Nigeria with that seen in other countries may bring better understanding of where Nigeria stands. The figure 5 below compares the policy environment in Nigeria with that seen in Malawi, Kenya, and Jamaica.



The figure shows that many other countries also rate the political and popular support for HIV/AIDS programs as quite high. Policy formulation, organisational structure and political support in Nigeria are considered as high as that for other countries affected by the HIV/AIDS epidemic. Nigeria however does not rate high in terms of the amount of resources allotted to the national response, the amount of effort put into the evaluation and research of the national response and the legal and regulatory framework, especially that which has to do with the elimination of stigma and discrimination towards persons affected by HIV/AIDS.

Discussion

The PES provides a useful means to determine the current status of the policy environment and verify the direction of change over time. This is in spite of the limitations of using a score that depends on the subjective assessment of a selected group of persons.

The present study shows that the policy environment for reproductive health programs in Nigeria is gradually improving. Some components of Reproductive health are better appreciated and supported by the government and other stakeholders. The policy environment of HIV/AIDS is better than that of family planning and Adolescent Reproductive health. The policy environment for Adolescent reproductive health is quite low.

When compared to the policy environment score for 2000 it is obvious that considerable improvement has occurred in all 3 components. The HIV/AIDS and ARH components show greater increase in the policy environment score when compared with the FP component. The improvements in the RH components' policy environment score ranged from 4.4% increase for the family planning, to 8.8% increase for STI/HIV/AIDS. The appreciation for adolescent reproductive health was 7.2%.

The existence of written policies that focus on delivering effective services to ameliorate stated problems was considered a high note in all 3 components. This was however associated with a poor funding for activities that would enable the achievement of the desired goals of the written polices. The provision of resources for policy implementation was considered inadequate for all 3 components of Reproductive health.

The elements of the policy environment that need improvement in all three RH components of the Reproductive health program include the coordination of activities between governmental and non-governmental organisations; the proper monitoring and evaluation of activities undertaken; and the use of the information derived for research and evaluation for policy planning and program formulation.

Recommendations

Improving funding in a country with a low GDP and a multitude of competing needs could be extremely difficult except if the case can be made of the urgency of the issue. This is expected to work in the

HIV/AIDS funding and incidentally it has better funding than the other components examined. It is possible that in the years to come the funding will rise. If the epidemic continues to grow, government and donors could be moved to increase such resources.

However fears still exist that at the slightest signs of controlling the epidemic funds could start to dry up.

1. There is therefore the need to continually advocate for improved funding for HIV/AIDS initiatives stressing the fact that the disaster is not over until the prevalence is below 1% and the epidemic could no longer be said to be generalised. Even then a lot will be needed for control and surveillance in the high risk groups.
2. Increased advocacy efforts could be accomplished by increasing the number and types of persons advocating for increased financing for HIV/AIDS.
3. Both the Rights-based approach as well as Needs-based approach could be used simultaneously in advocating for increased funding for Reproductive health programs.
4. Advocacy for increased funding in the ARH and Family Planning components, though more difficult to achieve will also have to be undertaken. NGO networks should be used to play a major role here
5. Advocacy in the ARH component could ride on the HIV/AIDS situation because adolescents and youth constitute a large high risk group and a window of opportunity. Indeed it is quite possible that the improved ARH PES is as a result of this.
6. Coordination of all 3 RH components will have to be improved upon by strengthening the institutions that are mandated to carry out this function and building up the capacity building of the persons within these institutions who ought to do the job. It is anticipated that such strengthening and capacity building will require technical assistance from outside the institutions, perhaps even from outside the country by organisations that have been able to perform these functions better.

The USAID, DFID and multilateral agencies have helped in the past; unfortunately the institutions have had difficulty in maintaining highly trained staff. There is obviously a need to train more personnel and reform the institutions such that a large number of persons are continually trained and given the skills and knowledge necessary to coordinate effectively.

7. The legal and regulatory framework of the ARH component will need strengthening. This includes laws and legislation to protect the rights of adolescents, especially female youth to

education, even if they get pregnant. The access of youth to contraceptives and youth friendly health services will need to be improved upon and the enforcement of laws to eliminate child marriages especially amongst in girls will go a long way to improve the reproductive lives of the Nigerian adolescent.

It is possible NGOs and NGO networks will have to be in the forefront of this advocacy effort as many of the issues here play upon the socio-cultural norms of Nigerians and will therefore be slow to change.

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